GREGG A. LOMBARDO, DDS, PA

HIPAA AUTHORIZATION FORM

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this notice about our privacy practices, our legal duties and your rights concerning your health information.

Such information may include documenting your symptoms, examination and test results, diagnoses, treatment and applying for future care or treatment. It also includes billing documents for those services.

With your consent, the practice is permitted by federal privacy laws to make uses and disclosures of your health information for purposes of treatment, payment and health care operations. You have the right to revoke or restrict this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent.

HIPAA: (Health Insurance Portability & Accountability Act) Our staff is HIPAA compliant to safeguard the privacy of patient's healthcare information in its entirety. A copy of the Notice of Privacy Practices is provided to you and is on display in the office waiting area.

SIGNATURE OF PATIENT OR RESPONSIBLE ADULT (18 YEARS AND UP)

_____

Printed Name

_____ _____

Signature Date

I authorize *Gregg A. Lombardo, DDS, PA* to disclose personal medical information to the following people: **(Drivers of sedated patients must be listed below)**

_____ _____

Name Relationship

_____ _____

Name Relationship